Supreme Court, U.S.
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No.

In the Supreme Court of the United States

ADENA REGIONAL MEDICAL CENTER; ET AL.,
Petitioners,

v.

MICHAEL O. LEAVITT, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

In calculating the Medicare disproportionate share hospital (DSH) adjustment, the Medicare statute directs the Secretary of Health and Human Services to count days attributable to patients who are "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act, which establishes the Medicaid program]." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (the "Medicaid Low Income Proxy").

The question presented, on which the federal courts of appeals are in conflict, is whether the Medicaid Low Income Proxy requires the inclusion of all patient days attributable to patients who are eligible for medical treatment under an approved State Medicaid plan or only those patient days for which a hospital actually receives payment from the Medicaid program (*i.e.*, Medicaid "paid" days).

LIST OF PARTIES AND RULE 29.6 STATEMENT

Petitioners are Adena Regional Medical Center; Alliance Community Hospital; Community Health Partners West Campus; Cuyahoga Falls General Hospital; East Liverpool City Hospital; Ft. Hamilton-Hughes Hospital; Good Samaritan Hospital & Health Center; Licking Memorial Hospital; Marietta Memorial Hospital; MedCentral Health System; Med-Health System-Greene; Memorial Hospital; Medical College Hospital; MetroHealth Medical Center; Miami Valley Hospital; MiddleTown Regional Hospital; Robinson Memorial Hospital; Southern Ohio Medical Center; St. Elizabeth Health Center; St. Joseph Health Center; Summa Health System; Trinity Health System; University of Cincinnati Hospital; Western Reserve Care System; Community Health Partners East Campus; and Trumball Memorial Hospital.

Pursuant to S.Ct. R. 29.6, Petitioners Adena Regional Medical Center, *et al.* are not-for-profit corporate entities. There is no parent company, subsidiary, or affiliate of any Petitioner that has outstanding securities in the hands of the public, and there is no publicly held corporation that owns 10 percent or more of the stock of any Petitioner.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully submit this petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the District of Columbia Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the District of Columbia Circuit is published at 527 F.3d 176 (D.C. Cir. 2008). App. 1a. The opinion decided Respondent's appeal from a memorandum and order of the United States District Court for the District of Columbia, which is published at 524 F. Supp. 2d 1 (D.D.C. 2007). App. 10a.

JURISDICTION

The United States Court of Appeals for the District of Columbia Circuit entered judgment on May 30, 2008. Petitioners filed a timely petition for panel rehearing and rehearing en banc in the Court of Appeals on July 14, 2008. The Court of Appeals denied the petition for panel rehearing and rehearing en banc on July 31, 2008. App. 21a-22a. The time for filing this petition was extended to December 28, 2008 by orders of the Chief Justice and Justice Stevens. No. 08A34 (Oct. 21, 2008; Nov. 18, 2008).

STATUTORY PROVISION INVOLVED

The Medicaid Low Income Proxy of the Medicare disproportionate share hospital (DSH) adjustment is defined as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act, which establishes the Medicaid program], but who were not entitled to benefits under part A of this subchapter [the Medicare statute], and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (the "Medicaid Low Income Proxy").

STATEMENT

I. Statutory And Regulatory Background

A. Congress Has Mandated An Adjustment In Medicare Funding For Hospitals Based In Part On Days Spent Serving Patients "Eligible For Medical Assistance Under An [Approved] State [Medicaid] Plan."

Medicare is a federal health insurance program that pays for covered medical care primarily to aged and disabled persons. 42 U.S.C. §§ 1395, *et seq.* Since 1983, reimbursement for hospitals' operating costs under Medicare has been governed by the Prospective Payment System (PPS), 42 U.S.C. § 1395ww(d). Under the PPS, an individual hospital's Medicare reimbursement is based not on its actual costs of treating Medicare patients, but on a predetermined amount for each patient depending on the patient's diagnosis at time of discharge. 42 U.S.C. § 1395ww(d)(1)-(4); 42 C.F.R. Part 412.

In 1983, Congress determined that hospitals that serve a disproportionately large number of low-income patients incur greater costs that are not met by the standard PPS calculation. Congress authorized the Secretary of the Department of Health and Human Services (HHS) to provide an adjustment, called the Medicare disproportionate share hospital (DSH) adjustment, to hospitals that serve a disproportionate share of low-income persons. *See* 131 Cong. Rec. S10931.

The Secretary refused, however, to promulgate regulations implementing the PPS and Medicare

DSH adjustment. *See Jewish Hospital, Inc. v. Secretary of Health and Human Services*, 19 F.3d 270, 272 (6th Cir. 1994) (noting the Secretary's long-standing "hostility" toward the PPS and Medicare DSH adjustments); *Samaritan Health Center v. Heckler*, 636 F. Supp. 503 (D.D.C. 1985) (chronicling the Secretary's unwillingness to promulgate PPS and Medicare DSH regulations).

When the Secretary refused to act, Congress did. In 1986, it pased the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272 (1986). In COBRA, Congress included a provision creating and defining the Medicare DSH adjustment. *Id.* at § 9105. Congress ordered the Secretary to provide a Medicare DSH adjustment to PPS payments for hospitals serving a disproportionately large number of low-income patients, and it mandated a specific formula for calculating that adjustment. *Id.*

Under the statutory formula, a hospital qualifies for a Medicare DSH adjustment if its "disproportionate patient percentage" meets or exceeds levels specified in 42 U.S.C. § 1395ww(d)(5)(F)(v). The hospital's disproportionate patient percentage is "defined as the sum of two fractions expressed as percentages," which serve as a "'proxy' for all low income patients." *Jewish Hospital*, 19 F.3d at 272.

The first fraction accounts for the number of "patient days" that a hospital spends serving patients who are "entitled" to Medicare Part A benefits and supplemental security income. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). This fraction, known

as the "Medicare Low Income Proxy" or the "Medicare Fraction," is not at issue in this case.

The second fraction accounts for "patient days" that a hospital spends serving patients who are "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act, establishing the Medicaid program], but who were not entitled to benefits under part A of [the Medicare statute]. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The construction of this second fraction—commonly known as the "Medicaid Low Income Proxy" or the "Medicaid Fraction"—is at issue here.

B. Medicaid Provides States With Considerable Discretion In Formulating Plans To Serve Low Income Patients, Both With Respect To Persons Covered And The Scope And Duration Of Covered Services.

Medicaid is a joint federal-state program, established by Title XIX of the Social Security Act. It provides health care benefits to indigent persons who are aged, blind, or disabled or members of families with dependent children. 42 U.S.C § 1396 *et seq.* Medicaid operates separately and apart from Medicare. However, like Medicare, Medicaid also provides for additional payments to hospitals that serve a disproportionate share of low-income patients—an adjustment known as the *Medicaid* disproportionate share hospital adjustment.

Under Medicaid, each state must submit to the HHS Secretary a state "plan for medical assistance" that meets broad federal requirements. That plan

must be approved by the Secretary under Title XIX of the Social Security Act. 42 U.S.C. § 1396a.

Within broad federal requirements, states are given discretion to determine the rules of eligibility, the type and range of services covered, and the payment levels for services under the state's Medicaid plan. 42 C.F.R. § 430.0. As a result, Medicaid plans vary from state to state, both with respect to persons covered and the scope and duration of covered services.[1]

C. Ohio Has Adopted A Medicaid Plan That Mandates Free Medical Treatment To Low-Income Ohio Residents Covered By The Ohio Hospital Care Assurance Program (HCAP).

Ohio participates in the Medicaid program and has adopted a plan of medical assistance that has been approved by the Secretary. App. 13a. The Ohio State Medicaid plan covers the individuals and services required by federal Medicaid statutes and regulations. *Id.* The Plan also mandates that hospitals provide free medical treatment to low-income Ohio residents who are ineligible for payments from Medicaid but who are covered by the Ohio Hospital Care Assurance Program (HCAP), Ohio Rev. Code § 5112.17(B), Ohio Admin. Code

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[1] For example, a number of states have Medicaid plans that limit the number of days of in-patient care for which Medicaid will pay. *See, e.g., Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261, 1262 (9th Cir. 1996); *Cabell v. Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984, 986 (4th Cir. 1996).

5101:3-2-07.17 and 5101:3-2-09(K)(5)(c). App. 13a-14a.

Under the Ohio State Medicaid plan, each hospital must provide "basic medically necessary hospital-level services" free of charge to patients who are residents of the State with income at or below the federal poverty line and not otherwise recipients of payments from Medicaid ("HCAP patients"). App. 5a-7a, 13a-14a (citing regulations included in the Ohio State Medicaid plan defining eligibility for free "basic medically necessary hospital-level services" and further defining the scope of "basic medically necessary hospital-level services" under the Plan).

The Ohio plan further provides that patient days attributable to HCAP patients must be considered in calculating a hospital's Medicaid DSH adjustment. App. 5a-7a, 13a-14a (citing Ohio Admin. Code 5101:3-2-07.17 and noting that that regulation was approved by the Secretary on April 6, 2001 for inclusion in Ohio's State Medicaid Plan); Ohio Admin. Code 5101:3-2-09(K)(5)(c)). Thus, the Ohio State Medicaid plan unambiguously provides hospitals with the opportunity to receive increased Medicaid funding through Medicaid DSH adjustments by providing services to HCAP patients, free of charge. App. 6a. And, in accord with the plan, hospitals (including Petitioners) have received Medicaid DSH adjustments based in part on the inclusion of patient days attributable to HCAP patients.

II. Facts And Proceedings Below

A. Petitioners File This Action To Have HCAP Patients Included In The Calculation Of Their Medicare DSH Adjustments.

Petitioners are twenty-five Ohio hospitals that participate in Medicare and Medicaid and seek to have patient days attributable to HCAP patients included in the calculation of their Medicare DSH adjustments. App. 2a, 10a, 13a-14a. The Secretary, through his fiscal intermediaries, refused to include HCAP patient days in the calculation of Petitioners' Medicare DSH adjustments. *Id.* Petitioners brought this action in federal court to challenge the Secretary's exclusion of HCAP patient days from the calculation of their Medicare DSH adjustments. *Id.*

B. The District Court Enters Judgment For Petitioners, Consistent With Unanimous Circuit Authority, Holding That HCAP Patients Must Be Included In The Calculations Of Medicare DSH Adjustments.

The district court entered summary judgment in Petitioners' favor, finding that: (1) the Medicaid Low Income Proxy unambiguously required the inclusion of patient days attributable to patients who are "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act, establishing the Medicaid program]"; and (2) HCAP patients are eligible for medical assistance under the Ohio State Medicaid plan, which has been approved by the Secretary under Title XIX of the Social

Security Act. App. 14a-18a (construing 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)).

In reaching this conclusion the court considered and rejected the Secretary's argument that the statutory phrase "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act]" was simply "'long-hand'" for "eligible" for payments from Medicaid. App. 14a-18a. "The statutory formula unambiguously directs the Secretary to include all "patients who ... were eligible for medical assistance under a State plan approved under [Title] XIX" in the Numerator [of the Medicaid Low Income Proxy. *Id.* "Congress said what it meant; if Congress had meant to restrict the Numerator to Medicaid-eligible patients, it could have explicitly done so. The phrase 'eligible for *medical assistance under a state plan approved under Title XIX*' is not 'long-hand' for 'eligible for Medicaid.'" App. 16a (emphasis in original). Because the regulations mandating treatment of HCAP patients were included in a "state plan approved under Title XIX," "the Secretary's exclusion of HCAP patients is inconsistent with the plain language of the statute and cannot be upheld." *Id.*

The specific application of the Medicaid Low Income Proxy's statutory language to HCAP patients was an issue of "first impression in federal courts." *Id.* But the district court noted that the Medicaid Low Income Proxy's language had been construed in a number of circuit court opinions. App. 16a-18a. "Every circuit court" that had construed the Medicaid Low Income Proxy had found that the statute unambiguously required the Secretary to count all patients who are "eligible for medical assistance under a State plan approved under [Title

XIX of the Social Security Act]," regardless of whether the hospital "actually received" payment from Medicaid for patient days attributable to that patient. App. 16a-18a (citing *Jewish Hospital, Inc.*, 19 F.3d at 273-76; *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996); *Legacy Emanuel Hospital*, 97 F.3d at 1265-66; *Cabell*, 101 F.3d at 986-93).

C. The D.C. Circuit Reverses The Judgment, Adopting A More Restrictive Reading Of The Medicaid Low Income Proxy And Holding That The Statute Does Not Reach Patients Who Are Not Eligible For Payment From Medicaid.

The Secretary appealed, and a panel of the Court of Appeals for the District of Columbia Circuit reversed. App. 1a-9a. Based upon its own reading of the Medicare statute, the panel concluded that HCAP patient days were properly excluded from the calculation of Petitioners' Medicare DSH adjustments because HCAP patients are not "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act, establishing the Medicaid program]." App. 3a-9a.

The panel acknowledged that (1) the Ohio State Medicaid plan includes provisions mandating that Petitioners provide medical treatment to low-income Ohio residents who meet the HCAP eligibility requirements set forth in the Plan and further mandating that HCAP patient days be counted in the Petitioners' Medicaid DSH adjustments; and (2) the Plan, including its HCAP provisions, had been approved expressly by the Secretary under Title XIX (governing Medicaid). App. 3a-9a. But the

panel nevertheless held that HCAP patients were not "eligible for medical assistance under a State plan" because Petitioners received no direct payment from the Ohio State Medicaid plan for providing medical treatment to HCAP patients. *Id.*

The panel reasoned that HCAP provisions included in the Ohio State Medicaid plan were not "part" of the plan within the meaning of the Medicaid Low Income Proxy because these provisions did not provide the Hospitals with a right to receive payments from Medicaid for HCAP patient days. App. 4a-6a.

The panel similarly construed the statutory term "medical assistance" to cover only "payments" made directly to Petitioners from Medicaid to reimburse them for the cost of providing medical care and services to patients. App. 7a-9a. In reaching this conclusion, the panel acknowledged that the Medicare statute did not define the term "medical assistance" in any respect. *Id.* The panel concluded, however, that (1) the term had to be construed to have the same meaning as in the federal Medicaid statute and (2) so defined, the term did not cover mandatory medical treatment and services that a hospital must provide at no charge under an approved State Medicaid plan. *Id.*

REASONS FOR GRANTING THE WRIT

This Court should grant certiorari to decide whether the Medicaid Low Income Proxy requires the Secretary to calculate the Medicare DSH adjustment based on all patient days attributable to patients who are eligible for medical treatment

under an approved State Medicaid plan or only those patient days for which a hospital receives payment from the Medicaid program (*i.e.*, Medicaid "paid" days). This Court has not directly addressed the construction of the Medicaid Low Income Proxy. The Courts of Appeals, however, are in conflict concerning the statute's construction, and the D.C. Circuit now has adopted a restrictive construction of the Medicaid Low Income Proxy that holds that a patient is "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act governing Medicaid]" if and only if a hospital receives payment for the patient's treatment from the Medicaid program. App. 3a-9a.

The D.C. Circuit's restrictive construction of the Medicaid Low Income Proxy has the effect of excluding from the calculation of Medicare DSH adjustments days of service to patients that are *not* paid directly by the Medicaid program. In contrast, the Fourth, Sixth, Eighth, and Ninth Circuits each have held that the Medicaid Low Income Proxy requires the inclusion of all days spent serving patients who are eligible to receive medical treatment and services under an approved State Medicaid plan, regardless of whether the Medicaid program actually pays the hospital for the costs of providing those days of service.

The D.C. Circuit's construction of the Medicaid Low Income Proxy cannot be reconciled with the decisions of the Fourth, Sixth, Eighth, and Ninth Circuits described above. The differences in the circuits' construction of the statute, moreover, are consequential to the outcome of cases, like this one, involving the calculation of Medicare DSH adjustments, leading to inconsistent results and

considerable confusion and uncertainty in the administration of the Medicare DSH adjustment.

For example, in this case, the D.C. Circuit held that HCAP patients were not "eligible" for "medical assistance" "under" the approved Ohio State Medicaid plan and that HCAP patient days, therefore, were properly excluded from the calculation of Petitioners' Medicare DSH adjustments. Yet, if the case had been decided in the Fourth, Sixth, Eighth, or Ninth Circuits, a very different construction of the Medicaid Low Income Proxy would have been employed following *Jewish Hospital*, *Deaconess Health Services*, *Legacy Emanuel Hospital*, and *Cabell*, and those circuit courts would not have excluded HCAP patient days from the calculation of Petitioners' Medicare DSH adjustments based on a lack of payment.

Likewise, the D.C. Circuit's construction of the Medicaid Low Income Proxy would have produced a different result in *Jewish Hospital*, *Deaconess Health Services*, *Legacy Emanuel Hospital*, and *Cabell*. Under the D.C. Circuit's construction of § 1395ww(d)(5)(vi)(II), those courts would have been forced to conclude that "unpaid" days of service were not attributable to patients who were "eligible" for "medical assistance" "under a State plan" approved under Title XIX of the Social Security Act because the hospitals received no payment from the plan for those patient days.

This Court's guidance therefore is needed to settle the law concerning the construction of the Medicaid Low Income Proxy. Without that guidance, Medicare DSH calculations cannot be made in a consistent and predictable manner that comports

with the plain language of the Medicaid Low Income Proxy and policy goals chosen by Congress. Instead, the outcome will vary from circuit to circuit in a manner that is unseemly, unfair to hospitals attempting to comply with the mandates of state plans, and inconsistent with Congress's desire to have a uniform statutory formula apply to Medicare DSH adjustments.

I. The Decision Below Conflicts With Decisions Of Other Circuits Construing The Statutory Formula For Calculating The Medicare DSH Adjustment.

A. Four Circuit Courts Have Held That The Medicare DSH Adjustment Must Include All Days Attributable To Patients Who Are "Eligible" To Receive Medical Treatment "Under" An Approved State Medicaid Plan, Whether Paid Directly By Medicaid Or Not.

Congress chose its words carefully when it amended the Medicare statute to include a provision creating and defining the Medicare DSH adjustment. In relevant part, Congress directed the Secretary to count patient days that a hospital spends serving patients who are "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act, establishing the Medicaid program], but who were not entitled to benefits under part A of [the Medicare Statute]. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The plain language of § 1395ww(d)(5)(F)(vi)(II)—requiring the inclusion of days spent serving patients who are "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act] but not entitled to benefits under part A of [the Medicare statute]—reflects Congress's judgment that the Secretary *should be* required to calculate Medicare DSH adjustments using a proxy that measures the "entire low-income population actually served by the hospitals" and provide an adjustment to Medicare PPS payments that reflects the disproportionately large share of hospital resources consumed by low income patients. *Portland Adventists Medical Center v. Thompson*, 399 F.3d 1091, 1099 (9th Cir. 2005) (citing the legislative history of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II)).

The plain language of the Medicaid Low Income Proxy and Congress's purpose in enacting the statute have led the Fourth, Sixth, Eighth, and Ninth Circuits to conclude that the Secretary must count all patient days attributable to patients who are "eligible" to receive benefits "under" an approved State Medicaid plan, regardless of whether the Medicaid program actually pays the hospital for the costs of providing those days of service. *See Jewish Hospital, Inc.*, 19 F.3d at 273-76; *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996); *Legacy Emanuel Hospital*, 97 F.3d at 1265-66; *Cabell*, 101 F.3d at 986-93.

The Sixth Circuit. In *Jewish Hospital*, an approved State Medicaid plan required participating hospitals to provide patients with medical treatment but the plan placed limits on the payments that a hospital could receive in reimbursement for its costs.

See Jewish Hospital, 19 F.3d at 273. As a result, under the State plan, hospitals routinely provided treatment to patients without necessarily receiving payment from the Medicaid program for certain days of patient care. *Id.*

When calculating the hospitals' Medicare DSH adjustments, the Secretary construed the Medicaid Low Income Proxy narrowly and concluded that the hospitals' Medicare DSH adjustments should be determined based *only* on the hospitals' "paid" days—*i.e.*, those patient days for which a hospital actually received payment from the Medicaid program. *Id.* The Secretary excluded from the hospitals' Medicare DSH calculations patient days *not* actually paid by the Medicaid program, reasoning that those "unpaid" days were not days attributable to patients who were "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act governing Medicaid)]." *Id.*

The hospitals challenged the Secretary's interpretation, and the Sixth Circuit agreed that the Medicaid Low Income Proxy unambiguously required the Secretary to count *all* days spent providing medical treatment to patients who received that treatment under the terms of an approved State Medicaid plan, regardless of whether the Medicaid program actually paid the hospital for the costs of providing those days of service. *Jewish Hospital*, 19 F.3d at 273.

"Looking at the plain language" of the Medicaid Low Income Proxy, the court reasoned that the statute is satisfied when a patient is "capable" of receiving benefits under the terms of an approved

State Medicaid plan, *period*. *Jewish Hospital*, 19 F.3d at 273-76. "The notion of 'eligibility' refers to the '*qualification*' for *benefits* or the *capability* of receiving those *benefits*" under an approved State Medicaid plan. *Id.* (emphasis added). "Congress explicitly refers to a period of *eligibility* equal to the time for which *medical assistance* was available. Congress, however, did not refer to the time period for which a given state actually renders Medicaid *payment*." *Id.* (emphasis added).

"Furthermore," when drafting the statutory formula for calculating Medicare DSH adjustments, "Congress spoke of 'eligibility' in the Medicaid proxy and 'entitlement' in the Medicare proxy." *Id.* (comparing the Medicaid Low Income Proxy, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), *with* the Medicare Low Income Proxy, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)). "Adjacent provisions utilizing different terms ... must connote different meanings." *Id.* Whereas the Medicare proxy uses the term "entitled" to "fix[]" the calculation upon the "absolute right to receive an independent and readily defined payment," "the Medicaid proxy speaks solely of eligibility" for medical assistance under an approved State Medicaid plan. *Id.* "Congress could not have intended to fix the [Medicaid proxy] calculation on the actual payment of benefits in the state administered program." *Id.* "Had Congress intended that result it would have defined the Medicaid proxy in terms of entitlement to state Medicaid payments." *Id.*

Finally, the court recognized that the "overarching intent" of Congress in enacting a statutory formula for calculating Medicare DSH adjustments weighed heavily on the natural

construction of the Medicaid Low Income Proxy. Congress's "'overarching intent" was to "supplement" the resources available to PPS hospitals serving low income persons. *Jewish Hospital*, 19 F.3d at 270. Given Congress's judgment about the higher costs associated with serving low-income patients and its unequivocal intent to provide an increase in Medicare PPS payments to supplement the resources of hospitals serving low-income patients, the court had no difficulty reading the Medicaid Low Income Proxy as establishing a method of accounting for all the days of service actually provided by a hospital to low-income patients under the terms of an approved State Medicaid plan, whether or not those days were actually paid for by Medicaid.

The Sixth Circuit's reading of the Medicaid Low Income Proxy led it to reject the Secretary's attempt to limit the Medicaid proxy used in the Medicare DSH calculation to those patient days for which a hospital receives payment from the Medicaid program. As the Sixth Circuit put it, the Medicaid Low Income Proxy "was intended to supplement and subsidize a PPS hospital's care for low income individuals, and the Secretary's [construction of the statute] runs counter to this clear intent by unnecessarily restricting the available subsidy, without foundation in the statute." *Jewish Hospital*, 19 F.3d at 275.

The Eighth Circuit. In *Deaconess Health Services*, 912 F. Supp. at 444-48, *aff'd*, 83 F.3d at 1041, the issue and result were the same. The Secretary, through his fiscal intermediaries, calculated hospitals' Medicaid Low Income Proxy and Medicare DSH adjustments based only on days of inpatient service for which a hospital received direct payment

from Medicaid and excluded days of service for which Medicaid provided no payment. 912 F. Supp. at 444-48. As in *Jewish Hospital*, the Secretary argued that all "unpaid" days should be excluded because "unpaid" days were not days attributable to patients who were "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act governing Medicaid]." *Id.* And in a decision that carefully analyzed the statutory language, the arguments of the parties, and the Sixth Circuit's decision in *Jewish Hospital*, the district court agreed with the hospitals that the Medicaid Low Income Proxy unambiguously required the inclusion of all days attributable to patients who were "eligible for medical assistance under a State plan approved under [Title XIX of the Social Security Act governing Medicaid], regardless of whether paid by Medicaid or not.

"The plain words of the statute indicate that the numerator is to consist of the patient days (without the limitation imported by the [Secretary]) which are attributable to patients 'eligible' for medical assistance under a state Medicaid plan." *Id.* at 447. "The Secretary's construction conflicts with the statute's focus on a patient's eligibility, by focusing on the state's actual payment to the hospital. The statute does not refer to patient days actually paid or actually reimbursed under Medicaid. The undersigned agrees with the reasoning of the *Jewish Hospital* majority." *Id.* The Eighth Circuit, in turn, affirmed the district court's judgment based on *Jewish Hospital* and the district court's thorough, well-reasoned opinion. 83 F.3d at 1041.

The Ninth Circuit. The same issue concerning the construction of the Medicaid Low Income Proxy

arose *In Legacy Emanuel Hospital*, 97 F.3d at 1265-66. And faced with the same arguments by the hospital plaintiffs and the Secretary, the Ninth Circuit reached the same conclusion as the Sixth and Eighth Circuits: "We believe the language of the Medicare reimbursement provision is clear: the Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits, whether or not Medicaid actually paid for those days of service. We base our conclusion on Congress's use of the word "eligible" rather than "entitled," as well as Congress's use of the Medicaid proxy to define non-Medicare low-income patients for purposes of determining a hospital's share of low-income patients." *Id.* (noting Congress's intent to mandate a proxy that accounted for all non-Medicare low-income patients served by hospitals participating in Medicare).[2]

The Fourth Circuit. In *Cabell*, 101 F.3d at 986-93, the Fourth Circuit weighed in and the court's

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[2] In the courts below, the Secretary noted that, in cases like *Legacy Emanuel Hospital*, the courts often substituted phrases like "Medicaid benefits" for the statutory term "medical assistance" when paraphrasing the Medicaid Low Income Proxy. The Secretary argued that such phrasing demonstrated that the statute did not apply to HCAP patients. However, that argument was squarely rejected in the district court, which described such references as "slips of language" that "are not even dicta" and which adopted a plain language construction of the statute that closely tracked the construction adopted in *Jewish Hospital* and the subsequent cases. Significantly, the D.C. Circuit panel opinion likewise did not rely on the language invoked by the Secretary from *Jewish Hospital* and the subsequent cases when it construed the Medicaid Low Income Proxy.

analysis closely tracked *Jewish Hospital*, *Deaconess Health Services*, and *Legacy Emanuel Hospital*. "It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the income, resources, and status qualifications specified by a particular state's Medicaid plan, whether or not they are actually receiving payment for a particular type of service or a particular duration of coverage." *Cabell*, 101 F.3d at 989. *Cabell* also considered and rejected a construction of the statutory term "medical assistance" comparable to one adopted by the D.C. Circuit here. *Id.* "The Secretary argues that 'eligible for medical assistance' cannot include hospital days which are unpaid by the state Medicaid plan because the Medicaid statute defines 'medical assistance' as 'payment.'" *Id.* The court noted, however, that the Secretary's argument failed to account for all the medical services included under Medicaid as well as the other terms and benefits that could be included in a State Medicaid plan. *Id.* "Hospital days need not be paid by a particular state Medicaid plan to be counted in the Medicaid proxy for the DSH calculation." *Id.*

B. The D.C. Circuit Has Adopted A More Restrictive Reading Of The Statute That Makes "Payment" Under Medicaid A Prerequisite For Inclusion In The Calculation Of The Medicare DSH Adjustment.

In this case, the D.C. Circuit adopted a fundamentally different reading of the Medicaid Low Income Proxy—a more restrictive reading of the statute that allows for the inclusion of only those

patient days for which a hospital actually receives payment from a State Medicaid program.

Although nothing in the text of the Medicaid Low Income Proxy makes "payment" for medical treatment a necessary (or relevant) criterion for determining whether a patient is "eligible" for medical assistance "under" an approved State Medicaid plan, the panel construed the statutory phrase "eligible ... under a State plan" restrictively to turn on "payment" from Medicaid for patient days. App. 3a-6a. This court held that the provisions included in the approved Ohio State Medicaid plan mandating the medical treatment of HCAP patients were not "part" of the State Medicaid plan within the meaning of the Medicaid Low Income Proxy because the provisions did not require payments to be made to hospitals from the Ohio State Medicaid program. App. 3a-6a (regulations requiring "mandatory charity care" could not be "part" of a State Plan, even when included in the text of the State Plan and submitted to and approved by the Secretary, because "an approved state Medicaid plan ... must pay providers for the care of eligible patients."). And based on this restrictive reading, the court also held that a patient is "eligible" for medical assistance "under" an approved State Medicaid plan only insofar as the approved State Medicaid plan provides for the payment of that particular patient's medical care. App. 3a-6a.

As part of its analysis, the court construed the statutory term "medical assistance" narrowly to cover only "payments" made directly to hospitals under Medicaid to reimburse them for the cost of providing medical treatment to patients and not "charity care" mandated by regulations included in a

State Medicaid plan. App. 7a-9a. Once again, however, nothing in the text of the Medicaid Low Income Proxy or any other part of the Medicare statute dictated that "medical assistance" be defined strictly in terms of a direct "payment" made to a hospital by a State Medicaid program. *Id.* The court took a different view, believing that the term should have the same meaning in this context as in the federal Medicaid statute. App. 7a-9a. There are a number of problems with the panel's reasoning.

To begin with, the court's analysis erroneously assumes that Medicare and Medicaid "operate together," as part of a single statutory scheme, using terms that are intended by Congress to have the same meaning. *Id.* (citing *Atl. Cleaners & Dyers, Inc. v. United States*, 286 U.S. 427, 433 (1932); *Sullivan v. Stroop*, 496 U.S. 478, 484 (1990)). This assumption reflects a misunderstanding of Medicare and Medicaid. As noted above, Medicare and Medicaid are separate programs with different goals and standards established by different federal statutes. Medicare is a federally administered public health insurance fund for the aged and disabled set forth in Title XVII of the Social Security Act. Medicaid, on the other hand, is a state-administered, public health insurance fund for the indigent, enacted separately from Medicare and codified in Title XIX of the Social Security Act.[3] Given these differences,

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[3] The distinction between the two statutes and programs is reflected in the case law. *Evanston Hospital v. Hauck*, No. 92 C 732, 1992 WL 205900, at*2 (N.D. Ill. Aug. 19, 1992) ("Medicare and Medicaid are entirely separate programs with different purposes and standards"), *aff'd*, 1 F.3d 540 (7th Cir. 1993); *Rastetter v. Weinberger*, 379 F. Supp. 170, 172 (D. Ariz. 1974)

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there is no basis for the panel's decision to borrow the statutory definition of "medical assistance" set forth in Medicaid and impose that definition on the text of the Medicaid Low Income Proxy. Indeed, Congress's decision to enact the Medicaid Low Income Proxy without defining "medical assistance" or cross-referencing the definition provided in Medicaid suggests that Congress did not intend for the term to be construed in a narrow or technical fashion using a definition borrowed from another statute.

There is nothing that suggests the term should be construed narrowly so as to cover only those patient days when payments are made directly to hospitals under Medicaid to reimburse them for the cost of providing medical treatment to patients. For example, in *Jewish Hospital*, the court had no difficulty in ruling that a patient could be eligible for "medical assistance" under an approved State Medicaid plan if the patient was capable of receiving a "benefit" under the terms of an approved State Medicaid plan, regardless of whether the hospital received a "payment" from Medicaid for that service. *Jewish Hospital*, 19 F.3d at 273-76. Indeed, the Sixth Circuit found it significant that Congress used the broad term "medical assistance" not "payment" in the text of the Medicaid Low Income Proxy. "Congress explicitly refer[ed] to a period of *eligibility* equal to the time for which *medical assistance* was available ... not ... the time period for which a given

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(Medicaid is a different law designed by Congress for a different purpose than Medicare), *aff'd*, 419 US. 1098 (1975).

state actually renders Medicaid *payment*" *Id.* (emphasis added). *See also Deaconess Health Services*, 912 F. Supp. 2d at 444-48 (same), *aff'd*, 83 F.3d at 1041; *Legacy Emanuel Hospital*, 97 F.3d at 1265-66 (same); and *Cabell*, 101 F.3d at 986-93.

Medicare regulations promulgated by HHS in response to *Jewish Hospital* and the other cases described above likewise belie the D.C. Circuit's narrow construction of "medical assistance" as covering only those patient days when direct payments are made by Medicaid to hospitals. *See* 42 C.F.R. § 412.106(b)(4)(i). In 1997, in response to *Jewish Hospital* and the other cases described above, HHS revised its interpretation of the Medicaid Low Income Proxy to state that "a patient is deemed eligible for Medicaid on a given day if the patient is eligible for *inpatient hospital services* under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, *regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver*." *Id.* (emphasis added).[4]

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[4] In Ruling 97-2, the Health Care Financing Administration (the agency within HHS responsible at the time for administering Medicare and Medicaid) responded to *Jewish Hospital*, *Deaconess Health Services*, *Legacy Emanuel Hospital*, and *Cabell*, and announced that it had "'chang[ed] its interpretation of [§ 1395ww(d)(5)(vi)(II)] to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits.'" *In re Medicare Reimbursement Litigation*, 414 F.3d 7, 9 (D.C. Cir. 2005) (quoting Health Care Financing Administration Ruling 97-2, at 1 (Feb. 27, 1997)) Significantly, however, the Secretary has refused to apply this new interpretation of § 1395ww(d)(5)(vi)(II) to cases like this one. As the district court noted in its summary judgment order,

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Indeed, in the wake of *Jewish Hospital*, the cases discussed above, and 42 C.F.R. § 412.106(b)(4)(i), certain "unpaid" days of care are now routinely included in the calculation of both Medicare DSH adjustments and Medicaid DSH adjustments.

None of these judicial rulings or agency pronouncements is consistent with the D.C. Circuit's narrow construction of "medical assistance" as covering only direct payments made to a hospital by an approved State Medicaid plan and not charity care or other unpaid benefits provided under the terms of an approved State Medicaid plan.

II. The Resolution Of The Conflict Presented Is Critically Important To The Uniform Administration Of The Medicare System And The Provision Of Medical Services To Low-Income Patients.

The conflict among the Courts of Appeals concerning the proper construction of the Medicaid Low Income Proxy is real, unavoidable, and of considerable practical importance. As described above, the conflict is producing inconsistent results in similar cases and engendering considerable confusion and uncertainty in the administration of the Medicare DSH adjustment. Hospitals participating in Medicare should not be subject to

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the Secretary's actions in this case are contrary to the plain language of both the Medicaid Low Income Proxy and this regulation. App. 19a.

differing constructions of the Medicaid Low Income Proxy and differing methods of calculating the Medicare DSH adjustments based on the circuit in which the hospital's claims are adjudicated.

This case provides the Court with an opportunity to resolve the conflict among the circuit courts, ensure that the Medicaid Low Income Proxy is administered in a uniform manner consistent with the plain language of the statute and the policy goals chosen by Congress, and hold that the statute requires the inclusion of all patient days attributable to patients who are "eligible" to receive benefits "under" an approved State Medicaid plan, regardless of whether the Medicaid program actually pays the hospital for the costs of providing those days of service.

CONCLUSION

Because the Circuits have adopted fundamentally different constructions of the Medicaid Low Income Proxy, producing different outcomes and engendering confusion and uncertainty, Petitioners urge that this Court's grant this petition.

Respectfully submitted,

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DECEMBER 24, 2008

United States Court of Appeals,
District of Columbia Circuit.

No. 07-5273

ADENA REGIONAL MEDICAL CENTER, et al.,
Appellees,

v.

Michael O. LEAVITT, Secretary of the United States Department of Health and Human Services,
Appellee.

Argued March 18, 2008.
Decided May 30, 2008.

Appeal from the United States District Court for the District of Columbia (No. 05cv02422).

August E. Flentje, Attorney, U.S. Department of Justice, argued the cause for appellant. With him on the briefs were Jeffrey S. Bucholtz, Acting Assistant Attorney General, Jeffrey A. Taylor, U.S. Attorney, and Anthony J. Steinmeyer, Attorney, U.S. Department of Justice. R. Craig Lawrence, Assistant U.S. Attorney, and Megan L. Rose, Attorney, U.S. Attorney's Office, entered appearances.

Murray J. Klein argued the cause and filed the briefs for appellees.

Before: SENTELLE, Chief Judge, and GINSBURG and BROWN, Circuit Judges.

Opinion for the Court filed by Circuit Judge GINSBURG.*

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* Circuit Judge BROWN concurs in the opinion of the Court except as to Part II.A.

GINSBURG, Circuit Judge: The Ohio Hospital Care Assurance Program (HCAP) ensures that indigent Ohioans who "are not recipients of the medical assistance program," *i.e.*, the Ohio Medicaid plan, nonetheless receive "basic, medically necessary hospital-level services" at no charge. OHIO REV. CODE § 5112.17(B); *see* Title XIX [Medicaid] of the Social Security Act, 42 U.S.C. § 1396 *et seq*. The state of Ohio does not reimburse hospitals for the cost of providing such mandatory charity care.

Seeking indirectly to cover some of their HCAP expenses, the 25 plaintiff-appellee hospitals took the position that the Secretary of Health and Human Services should include beneficiaries of the HCAP in calculating the monies the Hospitals are due under the Medicare program for the elderly and the disabled. *See* Title XVIII [Medicare] of the Act, 42 U.S.C. § 1395 *et seq*. The Secretary disagreed but the Hospitals successfully challenged his decision in the district court. 524 F. Supp. 2d 1 (2007). We now reverse that judgment.

I. Background

Under the Medicare statute, the Secretary generally pays hospitals a sum for each covered inpatient service without regard to the hospital's actual cost. *See* 42 U.S.C. § 1395ww(d). In 1983, however, the Congress determined any hospital that serves a disproportionately large percentage of low-income patients-known as a disproportionate share hospital (DSH)-should be reimbursed at a higher rate, apparently because the more low-income patients a hospital treats, the more it costs on average to care for Medicare patients. *See Cabell*

Huntington Hosp., Inc. v. Shalala, 101 F.3d 984, 985 (4th Cir. 1996) ("low-income Medicare patients have generally poorer health and are costlier to treat than high-income Medicare patients"). The Congress further determined the number of low-income patients each hospital treats should be measured indirectly by reference to the number of its patients "eligible for medical assistance under a State plan approved under [Title] XIX" of the Act, *i.e.*, Medicaid, "but ... not entitled to benefits under [Medicare]," 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Put simply, the more a hospital treats patients who are "eligible for medical assistance under a State plan approved under [*Medicaid*]," the more money it receives for each patient covered by *Medicare*.

II. Analysis

The question before us is whether HCAP patients are "eligible for medical assistance under a State plan approved under [Medicaid]." If so, then the Secretary miscalculated the DSH adjustments the Hospitals should have received under Medicare. We conclude for two reasons that the Secretary was correct, and accordingly was entitled to summary judgment: First, the HCAP provision that requires hospitals to care for indigent patients, § 5112.17(B), is not part of the Ohio "State plan approved under [Medicaid]" and, second, HCAP patients are not "eligible for medical assistance" within the meaning of that term in the Medicare DSH provision. We reach these conclusions based not upon any deference to the Secretary's interpretation but upon our own reading of the Social Security Act. *See Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 81

L.Ed.2d 694 (1984) (if the "Congress has directly spoken to the precise question at issue," then "that is the end of the matter").

A. HCAP Provision Is Not Part of Medicaid Approved Plan

Contrary to the Hospitals' argument, § 5112.17(B) is clearly not part of a "State plan approved under [Medicaid]" because an approved state Medicaid plan-as the Hospitals acknowledge in their brief-must pay providers for the care of eligible patients. *See* 42 U.S.C. §§ 1396a-1396b; *see also* § 1396d(a), (b). Section 5112.17(B) of the HCAP, however, requires the Hospitals to care for indigent patients without payment. *See also* OHIO ADMIN. CODE 5101:3-2-07.17. By its terms, moreover, § 5112.17(B) requires hospitals to care for patients only if they "are not recipients of the medical assistance program," that is, Medicaid. *See* OHIO REV. CODE § 5112.01 (defining "medical assistance program" as "the program of medical assistance established under section 5111.01 of the Revised Code and Title XIX [Medicaid] of the 'Social Security Act'"); *see also* § 5112.17(C) (hospital may "requir[e] an individual to apply for eligibility under the medical assistance program [Medicaid] before ... process[ing] an application under" § 5112.17). It is clear, therefore, that under Ohio law HCAP patients do not receive care pursuant to the Medicaid plan and, consequently, that HCAP patients are not eligible for care "under a State plan approved under subchapter XIX [Medicaid]" within the meaning of the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The Hospitals point out that the Secretary approved certain modifications to the Ohio regulation implementing § 5112.17(B) as an amendment to Ohio's Medicaid plan. True enough; *see* OHIO ADMIN. CODE 5101:3-2-07.17, approved by the Secretary April 6, 2001. Accordingly, the Hospitals maintain, the regulation must be part of the Ohio Medicaid plan: Why else would the Secretary have approved the regulation as an amendment to that plan?

The answer is not far to seek. The federal Medicaid statute contains its own DSH provision, which requires each state "specifically [to] define [ ]" eligibility for DSH adjustments in the state Medicaid plan and to "provide [ ] ... for an appropriate increase in the rate or amount of payment" eligible hospitals receive. *See* 42 U.S.C. § 1396r-4(a)(1).* Ohio acted pursuant to that provision to determine DSH adjustments in its Medicaid program by reference to a hospital's compliance with the requirement, set out in Rule 5101:3-2-07.17, that a hospital provide charity care under the HCAP. *See, e.g.,* OHIO ADMIN. CODE 5101:3-2-09(K)(5)(c) (hospitals are not eligible for Medicaid DSH adjustments if they do not provide charity care under the HCAP). Thus the regulation, which determines the eligibility of patients for such charity care, indirectly also determines the Hospitals' eligibility for and amount of DSH adjustments under the Ohio Medicaid plan. Federal law obliged Ohio to submit the regulation to the Secretary for approval because the mechanism

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* The Medicare DSH provision, in contrast, does not defer to the states on those questions. *See* § 1395ww(d)(5)(F).

for providing a DSH adjustment under Medicaid is part of Ohio's Medicaid plan, and the Secretary must approve that plan, *see* 42 U.S.C. § 1396r-4(a) (state plan does not satisfy requirement of § 1396a(a)(13)(A) unless state has submitted to Secretary methodology for making DSH adjustments); § 1396a(b) ("The Secretary shall approve any plan which fulfills the conditions specified in § 1396a(a)"); *see also* § 1396r-4(a)(3) (governing approval by Secretary of amendments made under § 1396r-4). The Secretary's approval of Rule 5101:3-2-07.17 does not suggest in any way that HCAP patients receive care pursuant to the Ohio Medicaid plan.**

** At oral argument the hospitals suggested § 5112.17(B) of the Ohio Code is part of the Medicaid plan because "their [Medicaid DSH] payments will increase if they're treating more HCAP patients and ... will decrease if they're treating less [sic] HCAP patients." The suggestion reflects a misunderstanding of the rationale for DSH adjustments. Hospitals in Ohio receive more DSH funds under the Medicaid plan the more HCAP patients they treat not because those patients receive care under the Medicaid plan, but because Ohio law treats such patients as a proxy for low-income patients, just as the Medicare provision treats Medicaid patients as a proxy for low-income patients. Thus, the Ohio Medicaid plan provides a hospital more money for Medicaid patients the more HCAP patients it treats, just as the federal Medicare statute provides a hospital more money for Medicare patients the more Medicaid patients it treats, *Cabell Huntington Hosp., Inc.*, 101 F.3d at 985.

B. HCAP Patients Are Not Eligible for "Medical Assistance"

As we noted at the outset, in order to prevail the Hospitals must demonstrate that patients who obtain charity care under the HCAP are "eligible for medical assistance under a State plan approved under [Medicaid]" within the meaning of that phrase in the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). As explained below, we conclude that the term "medical assistance," which is not defined in Title XVIII of the Act, has the same meaning in the Medicare DSH provision of Title XVIII as it has in the federal Medicaid statute, Title XIX of the Act; as a result, the Hospitals' case would fail even if HCAP patients did obtain care under the Ohio Medicaid plan for, as the Government points out, the federal Medicaid statute defines "medical assistance" as "payment of part or all of the cost" of medical "care and services" for a defined set of individuals, § 1396d(a), whereas the HCAP does not entail any payment.

First, we note the Medicare DSH provision in Title XVIII of the Act expressly refers to the Medicaid statute (as Title XIX of the Act), § 1395ww(d)(5)(F)(vi)(II), and the same phrase—"medical assistance under a State plan approved under [Medicaid]"—appears throughout the Act.* As the Supreme Court has instructed on countless occasions, we are to presume "identical words used in different parts of the same act are intended to

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* *See, e.g.*, 42 U.S.C. §§ 1320a-7b(a)(6), 1382h(b)(3), 1396a(a)(10)(E), 1396n(i)(1).

have the same meaning." *Atl. Cleaners & Dyers, Inc. v. United States*, 286 U.S. 427, 433, 52 S.Ct. 607, 76 L.Ed. 1204 (1932); *see also Sullivan v. Stroop*, 496 U.S. 478, 484, 110 S.Ct. 2499, 110 L.Ed.2d 438 (1990) (applying canon where "cross-references" indicate two administrative programs within Social Security Act "operate together").

Second, and perhaps more probative, the Medicaid DSH provision permits the states to adjust DSH payments "under a methodology that" considers either "patients eligible for medical assistance under a State plan approved under [Medicaid] or ... low-income patients," 42 U.S.C. § 1396r-4(c)(3)(B), such as those served under the HCAP. The Medicaid and Medicare DSH provisions serve the same purpose-to adjust payments to hospitals that serve a disproportionate share of poor patients-and in doing so each refers to patients "eligible for medical assistance under a State plan approved under" the Medicaid title of the Act. *Id.*; § 1395ww(d)(5)(F)(vi)(II). It stands to reason the Congress intended the quoted phrase to have the same meaning in the two provisions.

We thus conclude HCAP patients do not obtain, and are not eligible for, "medical assistance" within the meaning of the Medicare DSH provision, wherefore the Hospitals' case must fail. As the Fourth Circuit has noted, "[i]f Congress had wanted 'medical assistance' to take on a completely different meaning" in the Medicare DSH provision in Title XVIII than it has in the Medicaid statute, Title XIX, then the "Congress could easily have so indicated." *Cabell Huntington Hosp., Inc.*, 101 F.3d at 990.

III. Conclusion

In sum, we conclude the HCAP provision requiring the Hospitals to care for indigent patients is not part of the Ohio "State plan approved under [Medicaid]" and the indigent patients covered by the HCAP provision are not "eligible for medical assistance" within the meaning of the Medicare statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).* Therefore, the judgment of the district court is

Reversed.

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* The Hospitals' other arguments are sufficiently lacking in merit as not to warrant consideration in a published opinion.

United States District Court,
District of Columbia.

ADENA REGIONAL MEDICAL CENTER, et al.,
Plaintiffs,

v.

Michael A. LEAVITT, Secretary, United States Department of Health and Human Services,
Defendant.

Civil Action No. 05-2422 (LFO).

June 11, 2007.

MEMORANDUM

LOUIS F. OBERDORFER, District Judge.

This case involves a challenge to the Secretary of Health and Human Services' interpretation of the statutory formula for providing reimbursements under Medicare to hospitals that serve a disproportionately high share of low-income patients. For reasons explained below, the Plaintiffs' Motion for Summary Judgment is granted, and the Defendant's Cross-Motion for Summary Judgment is denied.

I. Background and Procedural History

A. The Statutory Framework

i. The Medicare Scheme and the "Disproportionate Share Adjustment"

The Medicare program provides health insurance to elderly and disabled persons. *See* 42 U.S.C. § 1395 *et seq.* The Secretary is authorized to promulgate regulations prescribing the health care services

covered by the program and the methods of determining payments for those services. The operating costs of inpatient hospital services are reimbursed by Medicare primarily through a prospective payment system. *See* 42 U.S.C. § 1395ww(d). This system contains a number of statutory provisions that adjust reimbursement based on hospital-specific factors. *Id.*

In 1985, Congress enacted legislation directing the Secretary to include an adjustment to provide additional Medicare payments to hospitals that serve a "significantly disproportionate number of low-income patients." It was called the "disproportionate share hospital ('DSH') adjustment" (the "Adjustment"). Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, § 9105 (1986); 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Congress also established a specific formula for calculating the Adjustment; whether a hospital qualifies for the Adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." 42 U.S.C. § 1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the Medicare fraction and Medicaid fraction for a hospital's cost reporting period. 42 U.S.C. § 1395ww(d)(5)(F)(vi). The first fraction, the Medicare fraction, is based on the number of Medicare patients who qualify for Supplemental Security Income. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The second fraction, the Medicaid fraction, is based on the number of non-Medicare low-income patients served by the hospital.

The proper calculation of the numerator in the Medicaid fraction (the "Numerator") is the dispute in

this case. The text of the statute, as amended in 2005, is as follows:

> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [Medicaid], but who were not entitled to benefits under part A of this subchapter [Medicare-Part A], and the denominator of which is the total number of the hospital's patient days for such period.
>
> In determining ... the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI of this chapter.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

ii. The Medicaid Scheme (Title XIX)

Title XIX of the Social Security Act (Medicaid) authorizes the use of federal funds to help states offset the cost of providing medical assistance to eligible low-income individuals. *See* 42 U.S.C. § 1396

et seq. To receive these funds, a state must submit a "state plan" for approval by the Secretary, and it must administer the plan according to Medicaid requirements. 42 U.S.C. § 1396d(a). Only expenditures made under an approved Medicaid state plan become eligible for matching federal payments. 42 U.S.C. § 1396d(a)-(b).

B. The Undisputed Facts

Plaintiffs are 25 hospitals that participate in Ohio's Hospital Care Assurance Program ("HCAP"), a part of Ohio's state health plan ("State Plan"). Ohio's State Plan has been approved by the Secretary under Title XIX. Pls.' Statement of Material Facts ¶ 1; Def.'s Statement of Material Facts ¶ 3. HCAP provides coverage for medical assistance provided to low-income Ohio residents otherwise ineligible for traditional Medicaid. Def.'s Statement of Material Facts ¶ 6(a); Pls.' Response ¶¶ 2, 6. The state of Ohio receives some federal matching funds for HCAP days under the Medicaid statute. Pls.' Response ¶¶ 3. Medicare funds are administered and paid to providers through fiscal intermediaries. The fiscal intermediary for the Plaintiff Hospitals has not allowed the Hospitals to include HCAP days in calculating their Medicare DSH adjustment. Pls. Statement of Material Facts ¶ 1. The Ohio plan at issue in this case is a traditional state plan that includes provisions for reimbursing hospitals for certain services provided to low-income patients not eligible for traditional Medicaid.

C. Procedural History

The Hospitals timely filed appeals of the fiscal

intermediary's determination to the Provider Reimbursement Review Board (the "Board"). *See* 42 U.S.C. § 1395oo(a). On December 7, 2005, the Board determined that it lacked authority to decide the appeal because it involved "a question of law" and granted Expedited Judicial Review. *See* 42 U.S.C. § 1395oo(f)(1).

The Hospitals subsequently brought this action in federal court. On February 1, 2006, they moved for summary judgment [dkt. 7-1]. On March 29, 2006, the Secretary filed a cross-motion for summary judgment [dkt. 16]. On December 22, 2006, the Court's Calendar Committee transferred to me the cross-motions for summary judgment for decision. *See* Local Civil Rule 40.6(a).

The central issue is whether or not the Secretary's interpretation of the phrase "eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [the Medicaid statute]" is consistent with the plain language of the statute.

II. Discussion

A. Standard of Review

Summary judgment is appropriate where "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). This case presents a pure question of law.

In reviewing the Secretary's interpretation, a

court looks to the statutory language and legislative history to determine if Congress has directly spoken to the precise question at issue. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). When "the statutory scheme is coherent and consistent" and "the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case," no deference to the agency is required. *Barnhart v. Sigmon Coal Co., Inc.*, 534 U.S. 438, 450, 122 S.Ct. 941, 151 L.Ed.2d 908 (2002) (quoting *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340, 117 S.Ct. 843, 136 L.Ed.2d 808 (1997)). The court's role is to ensure that Congressional intent is given effect. If, however, the statute is "silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Chevron*, 467 U.S. at 843, 104 S.Ct. 2778. It is not sufficient for a plaintiff to offer an alternative, equally permissible construction. *Id.* at 843 n. 11, 104 S.Ct. 2778.

B. Analysis

Plaintiffs argue that the phrase "eligible for medical assistance under a State plan approved under subchapter XIX of this chapter" is unambiguous. It is undisputed that HCAP is part of Ohio's State Plan and that the State Plan has been approved by the Secretary under Title XIX. Thus, Plaintiffs argue, *by definition,* the Numerator should include HCAP patients.

The Secretary argues that he has reasonably interpreted the same phrase to mean "eligible for

Medicaid;" that the phrase in the statute is "long-hand"; and that the terms are interchangeable. He seems to assert that the statute is ambiguous, or at least not "clearly unambiguous." Thus, the Secretary asserts that his reasonable interpretation is entitled to deference; the statute does not require him to include HCAP patients in the Numerator. He further argues that exclusion of HCAP patient days is proper because those individuals are clearly not eligible for Medicaid.

The Secretary's argument is unpersuasive. The statutory formula unambiguously directs the Secretary to include all "patients who ... were eligible for medical assistance under a State plan approved under [Title] XIX" in the Numerator. § 1395ww(d)(5)(F)(vi)(II). "[T]he statutory scheme is coherent and consistent" and "the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case." *Barnhart*, 534 U.S. at 450, 122 S.Ct. 941. Congress said what it meant; if Congress had meant to restrict the Numerator to Medicaid-eligible patients, it could have explicitly done so. The phrase "eligible for *medical assistance under a state plan approved under Title XIX* " is not "long-hand" for "eligible for Medicaid." It is undisputed that HCAP is a "state plan approved under Title XIX." Accordingly, the Secretary's exclusion of HCAP patients is inconsistent with the plain language of the statute and cannot be upheld.

The application of the Numerator to patients covered by plans like the one at issue in the present case is an issue of first impression in federal courts. However, it is not the first time that federal courts

have addressed the Secretary's interpretation of the Numerator. From 1986 through 1997, the Secretary construed the first portion of this Numerator to include only those patients who were *both* eligible for Medicaid payments under the relevant state Medicaid plan and for whom the hospital *actually received* such payments from the state. Providers challenged this interpretation, arguing that the statute unambiguously required the Secretary to include all days for which a patient was *eligible* for Medicaid, not just the days for which Medicaid was paid. Every circuit court that subsequently considered the Secretary's interpretation uniformly concluded that the word "eligible" should be given its plain meaning; the Numerator unambiguously includes all patient days for which a patient was *eligible* for Medicaid regardless of whether a state Medicaid program actually paid the hospital for services provided to the patient. *See Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 988 (4th Cir. 1996); *Legacy Emanuel Hosp. and Health Ctr. v. Shalala*, 97 F.3d 1261, 1266 (9th Cir. 1996); *Deaconess Health Servs. Corp. v. Shalala*, 83 F.3d 1041, 1041 (8th Cir. 1996); *Jewish Hosp., Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270, 276 (6th Cir. 1994). Similarly, the statute should be given its plain meaning here. The Secretary points out that these courts often substituted "Medicaid" for "medical assistance" in paraphrasing the statute. He argues that this proves that the terms are interchangeable, but those slips of language are not even dicta. Nor do such statements suggest that the statutory language is ambiguous; the part of the phrase at issue here was not before those courts.

Finally, while the plain language of the statute

speaks for itself, it is noteworthy that Congress' purpose in enacting the Adjustment was based on its determination that care for low-income patients consumes a disproportionately large share of hospitals' resources, resulting in higher Medicare costs. *See* H.R. Rep. No. 99-241, at 16 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 594. The Adjustment was clearly intended to measure "the entire low-income population actually served by the hospitals." *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1099 (9th Cir. 2005).[1]

III. Conclusion

For the foregoing reasons, in an accompanying order Plaintiffs' motion for summary judgment is granted, and Defendant's cross-motion for summary judgment is denied.

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[1] This case addressed the Secretary's exclusion of patient days covered by a state "demonstration project authorized under title IX." In 2005, Congress amended the statute to give the Secretary discretion to include or exclude such patients. *See* Deficit Reduction Omnibus Act of 2005, Pub. L. No. 109-171, § 5002. Both Parties agree, and I conclude, that the 2005 amendment did not alter the application of the statute to state plans approved under Title XIX.

United States District Court,
District of Columbia.

ADENA REGIONAL MEDICAL CENTER, et al.,
Plaintiffs,

v.

Michael A. LEAVITT, Secretary, United States Department of Health and Human Services,
Defendant.

Civil Action No. 05-2422 (LFO).

June 11, 2007.

ORDER

For the reasons explained in an accompanying memorandum opinion, it is this 11th day of June, 2007 hereby

ORDERED: that Plaintiffs' Motion For Summary Judgment [dkt # 7] is GRANTED; and it is further

ORDERED: that Defendant's Cross-Motion for Summary Judgment [dkt # 16] is DENIED; and it is further

ORDERED: that the Defendant's interpretation of the Medicare statute and 42 C.F.R. 412.106(b)(4) to exclude Ohio's Health Care Assurance Plan ("HCAP") patients from the calculation of the Disproportionate Hospital Share Adjustment is REVERSED; and it is further

ORDERED: that the above-captioned matter is remanded to the Secretary of the Department of Health and Human Services. The Secretary shall

instruct the Fiscal Intermediary in Ohio: (1) to correct each of the Plaintiff Hospitals' cost reports at issue to include HCAP days; (2) to recalculate the Disproportionate Hospital Share Adjustment accordingly; and (3) to make the resulting payment within 90 days of receiving the required documentation from the Hospitals; and it is further

ORDERED: that the payments shall include an award of interest pursuant to 42 U.S.C. § 1395oo(f)(2); and it is further

ORDERED: this Court retains jurisdiction in this matter pending further order.

/s/

Louis F. Oberdorfer

UNITED STATES DISTRICT JUDGE

United States Court of Appeals,
District of Columbia Circuit.

No. 07-5273

ADENA REGIONAL MEDICAL CENTER, et al.,
Appellees,

v.

Michael O. LEAVITT, Secretary of the United States Department of Health and Human Services,
Appellee.

Filed: July 31, 2008

BEFORE: Sentelle, Chief Judge, and Ginsburg and Brown, Circuit Judges

ORDER

Upon consideration of appellees' petition for panel rehearing filed on July 14, 2008, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk
BY: /s/
Michael C. McGrail
Deputy Clerk,
United States Court of Appeals, District of Columbia Circuit.

United States Court of Appeals,
District of Columbia Circuit.

No. 07-5273

ADENA REGIONAL MEDICAL CENTER, et al.,
Appellees,

v.

Michael O. LEAVITT, Secretary of the United States Department of Health and Human Services,
Appellee.

Filed: July 31, 2008

BEFORE: Sentelle, Chief Judge, and Ginsburg, Henderson, Randolph, Rogers, Tatel, Garland, Brown, Griffith, and Kavanaugh, Circuit Judges.

ORDER

Upon consideration of appellees' petition for rehearing en banc, and the absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk
BY: /s/
Michael C. McGrail
Deputy Clerk,
United States Court of Appeals, District of Columbia Circuit.